PATIENT INFORMATION

(CONFIDENTIAL)

Date: _______________ Date of Birth: _______________ SSN:_______________________

Name: _______________________________ Male ___ Female ___ Unspecified ___ Cell Phone:_________________ Home Phone: __________________

Address: ____ City: _____________________ State: ______ Zip Code: ___________________

Email Address: ____ Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated ____

Patient's or Parent's Employer: ____ Work Phone: ___________________________________

Business Address: ____ City: _____________________ State: ______ Zip Code: ___________________

Spouse or Parent's Name: ___________________________ Employer: __________________________ Work Phone: ______________________________

Referring Dentist: ____

Emergency Contact and Relationship: ____Telephone #____

FINANCIALY RESPONSIBLE PARTY

Name of Person Responsible for this Account: ___________________________________ Relationship to Patient: ___________________________

Address: ____ City: ________________________ State: _______ Zip Code: ______________

Date of Birth: _______________ Cell Phone: ______________________________ Driver's License #: _______________________________

Employer: _______________________________ Work Phone: ______________________________ Is this Person Currently a Patient of our Office? Y / N

INSURANCE INFORMATION

Policy Holder: ____ Relationship to Patient: ___________________________________

Birthdate: __________________ Social Security #: _______________________ Name of Employer: ______________________________________

Employer Phone: _______________________ Insurance Company: ____

Insurance Phone #: _______________________ Insurance ID #: ___________________________ Group #: ____________________________

Insurance Claim Address: ___________________________________ City: ______________________ State: _______ Zip Code: ____________________

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PATIENT MEDICAL HISTORY

Patient Name: ___________________________ Height: _______ Weight: _________

Physician: _____________________________________ Office Phone #: ________________________ Date of Last Exam: ______________________

	Yes	No
1. Are you under medical treatment now?	___	___
2. Have you ever been hospitalized for any surgical operations or serious illness? …………………………	___	___
3. List all of the medicines you take: ___________________________________		
4. Do you use tobacco or alcohol?…………………	___	___
5. Do you use marijuana or any other recreational drugs?	___	___
6. Are you wearing contact lenses? …………………	___	___
7. Do you have TMJ Dysfunction? …………………..	___	___
8. Do you take "Diet" pills? ……………………………	___	___

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	Yes	No
9. Are you allergic to or have you had any reactions to the following…………………	___	___
Local Anesthetics (e.g. Novocain) …………..	___	___
Penicillin …………………..…………………	___	___
Sulfa Drugs ……………………………….……	___	___
Barbiturates/Sedatives ….……………………...	___	___
Iodine …..…………………………………………	___	___
Aspirin ……………………………………………..	___	___
Food Allergies ……………………………………	___	___
Other: ________________________________	___	___
10. Women Only:		
a) Are you pregnant or think you may be?	___	___
b) Are you nursing? ……………………………	___	___
c) Are you taking birth control pills? …………	___	___

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11. Do you have or have you had any of the following?

	Yes	No
High Blood Pressure ……………………………………	___	___
Heart Attack ……………………………………………...	___	___
Rheumatic Fever ……………….……………………..	___	___
Swollen Ankles …………………………………………..	___	___
Fainting/Seizures ………………………………………..	___	___
Asthma …………………………………………………	___	___
Low Blood Pressure …………………………………….	___	___
Epilepsy/Convulsions …………………………………..	___	___
Leukemia …………………………………………………	___	___
Diabetes …………………………………………………	___	___
Kidney Diseases ………………………………………..	___	___
AIDS or HIV Infection …………………………………..	___	___
Thyroid Problems ……………………………………….	___	___
Heart Disease ……………………………………………	___	___
Cardiac Pacemaker ……………………………………..	___	___
Heart Murmur …………………………………………….	___	___
Angina ……………………………………………………..	___	___
Frequently Tired ………………………………………….	___	___
Anemia …………………………………………………….	___	___
Emphysema ……………………………………..	___	___
Cancer ……………………………………………	___	___
Arthritis …………………………………………...	___	___
Joint Replacement or Implant …………………	___	___
Hepatitis/Jaundice ………………………………	___	___
Sexually Transmitted Disease ………………...	___	___
Stomach Troubles/Ulcers ………………………	___	___
Chest Pains ………………………………………	___	___
Easily Winded ……………………………………	___	___
Stroke ……………………………………………..	___	___
Hay Fever/Allergies ……………………………..	___	___
Tuberculosis ……………………………………..	___	___
Radiation Therapy ……………………………….	___	___
Glaucoma …………………………………………	___	___
Recent Weight Loss …………………………….	___	___
Liver Disease …………………………………….	___	___
Heart Trouble …………………………………….	___	___
Respiratory Problem …………………………….	___	___
Other: ______________________________	___	___

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or parent if minor): ____Date:_______________